LETTERS *to the Editor*

Sleep Apnea

TO THE EDITOR: In the article "Sleep Apnea Syndrome" (West J Med 123:7-16, Jul 1975) I missed Cheyne-Stokes breathing and its preventive treatment. If it leads to sleep apnea, this periodic respiration is due to diminished sensitivity of the respiratory center in the medulla caused by lack of oxygen. It is seen most frequently in arteriosclerotic and hypertensive patients in advanced stages of their cardiovascular disease. Aminophyllin intravenously is the remedy of choice and acts by stimulation of the respiratory center, whereas barbiturates and other sedatives are without avail and morphine is strictly contraindicated. The stimulating action of aminophyllin upon the respiratory center, if injected intravenously, was first discovered and therapeutically used in 1927 by my former assistant A. Vogel.[1]

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On Informing the Patient

TO THE EDITOR: During this unhappy period of widespread distress concerning insurance coverage and the potentials of being sued, the profession has had to face more than usual criticism. Even though much of the criticism does not seem to be factually founded or justified, one wonders whether some good might be derived from this display of public complaints. Despite the necessity of having to accept that in some instances some physicians have failed to conduct their activities in the best interests of their patients, the profession as a whole should not be jockeyed into a defensive position. Yet under these circumstances it seems reasonable for the profession to "take a look in the mirror" and to ask if there are some aspects of the manner in which modern clinical practice is conducted that might be contributory to present miseries and if there are changes that can be made for improvement.

For several decades the public has been avalanched with medical and scientific information and because it is avidly received the media provide more and more. "Public education" of this type may be good in its ultimate, but since the information thus presented is superficial it tends to stir personalized interest without providing bases for judgment. Nevertheless, "Mr. John Doe" has learned to ask questions, to assume a doubting attitude and to expect answers. The query the profession might consider from its "view in the mirror" is whether it has kept pace with the public by being willing to take the time to answer questions and to explain the circumstances medically. Explanation and full discussion with patient and family have always been recognized and utilized by the physician as good supportive therapy since it is the direct means of allaying anxiety and unjustified fears. But it would seem that John Doe's attitude, which nowadays is so different from the old—"doctor knows best"—tends to cause practitioners to remain aloof and sometimes, almost wordless—until all the test results are in!

Those of us in academic medicine—cloistered in the proverbial "ivory towers"—can be as inadequate or even more so in this type of communication with patients than are those in private practice. Additionally, academic medicine may well have failed to keep pace with the changing times by not including designed instruction by example or otherwise in how and when to deliver medical information to the patients and their families.

From the point of view of an academic consultant in a medical specialty, a frequent statement heard from patients and their families is some variation of "Gee, why didn't the doctor tell me?" Recently, this consultant was told more specifically: "If the doctor had been more willing to talk about my wife's problem, I would not have discussed the situation with my attorney!" Hopefully, no suit will follow in this instance for nothing professionally wrong occurred, unless inadequate communication between doctor and patient will be construed as malpractice.

The total circumstances of the present regarding patient-doctor relationships are far too complex to bring down to one simple explanation. However, if there be one, the "Achilles heel" of

modern medical practice might reasonably be considered to be in the failure of the physician to provide information to those who are concerned as it develops.

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Withholding of Physicians' Services

TO THE EDITOR: I enjoyed your editorial essay "On the Withholding of Physicians' Services" [West J Med 123:136-138, Aug 1975] far more than mere words can express to you. There are many of us who are appalled at the callousness of doctors who went on strike. Any good that we were accomplishing in terms of public image and legislative goals was by that action badly compromised, if not negated.

Even the most conservative of us must admit that the tripling or quadrupling of premiums had created a crisis. The real point of the problem was why had this not been anticipated by our leaders? I know that you, among others, have been aware for a long time of the precarious fiscal position of our professional liability carriers in regards to this segment of their business operation. It seems to me that for at least four to five years organized medicine has been stalling and not really addressing itself to the basic issues of the rising incidence of claims and their source in the attitude of the public, not the increased incidence of physician error.

This was actually more of a social than an insurance or medical care problem, as we all know.

Thank goodness there will be some tort remedies and I am happy to join with you in the approach that you have taken.

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"Gurney" Again— Scots Origin Theory Scotched?

TO THE EDITOR: The suggestion of Dr. J. B. deC. M. Saunders (West J Med 122:515-516, Jun 1975) that the word "gurney" derives from the Scots verb "girn" (meaning to groan in pain, to complain persistently, etc.) appealed very much to my sentimental Celtic (Welsh) nature. However, his assertion that "the word gurney for a wheeled stretcher is common in Scotland and the North of England" was harder for me to swallow because I once worked in a hospital in the North of England and never once heard the word.

Therefore, I recently appealed to the faculties of Scottish university medical schools for information and I have now received replies from Aberdeen,[1] Dundee,[2] Edinburgh[3] and Glasgow.[4] The answers reveal that although "girn" does mean to complain persistently, "gurney" is unknown in Scotland. It is certainly not used to describe a wheeled stretcher; in Scotland, as in England, such a conveyance is known as a trolley.

It seems to me that the best present theory is still that "gurney" was somehow derived from the gurney cab or bus.[5,6]

Further support of this idea is contained in a 1966 article recently brought to my attention by its author, P. Tamony.[7] Apparently, a gurney was a horse-drawn rear-entrance cab with two seats set longitudinally, facing each other. It was named after its inventor, J. Theodore Gurney of Boston who was granted a United States patent for it in 1883.

At the end of the 19th century Gurney Cab companies existed in both San Francisco and Oakland. One can probably assume that they were so named after the type of cab which they used (at any rate, the proprietors of the Oakland company were named Kane and Daly). A Gurney Cab Company operated in Vancouver as well and there too, it seems, the word came to be applied to the wheeled stretcher.[8]

According to Tamony, San Francisco police wagons and ambulances came to be known as gurneys, presumably because they also had rear entrances. So perhaps it was only a small jump to apply the word to any wheeled vehicle designed to carry a sick or injured person.

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